EZETT Youth & Family Services
Family Support Services Referral Form
Phone: 804-262-9479 * Fax: 855-515-0804 * Email: faptcases@ezettyfs.org

Today's Date: _____ **FAPT Approval:** ☐ **Yes** ☐ **No**

Service Request Information

Requested Start Date: _____

Virtual Residential Program: ☐
Structured Family Visitation: ☐
Therapeutic Mentoring: ☐
Parent Coaching and Support: ☐
Parent and Family Assessment: ☐
Home and Community Based Counseling: ☐
Supervised visitation: ☐
Transportation: ☐
1:1 Support Services: ☐

Referral Source

Agency: **Name:**
Phone Number: **Fax Number:** **Email Address:**
Name of Legal Guardian: **Relationship to Child:**
Phone Number: **Afterhours Contact Information:** **Email Address:**

Legal Information

Guardian Ad Litem: **Phone Number:**
Probation Officer: **Phone Number:**
DSS Social Worker: **Phone Number:**

Client Information

First Name: __________________ **Middle Name:** __________________ **Last Name:** ______________

Birth Date: __________________ **Age:** ___________ **SSN:** ________________________
Gender: ____________________________________ **Race:** ______________________________________

Address: ______________________________
City: ______________________________ **State:** ____________ **ZIP:** ________________________
Phone: ____________________

Family Information

Mother: **Phone:** **Address:**
Father: **Phone:** **Address:**
If the child is placed in foster care or outside, the home please complete the following:
Supervised Visitation: ☐ Yes ☐ No
Frequency: ☐ Weekly ☐ Twice a Week ☐ Bi-weekly ☐ Other:________________
Location of Visitation: ☐ Family's Home ☐ DSS ☐ Community ☐ Other

Approved Participants: ☐ Parents ☐ Siblings ☐ Grandparents ☐ Other

EZETT Youth & Family Services
Family Support Services Referral Form
Phone: 804-262-9479 * Fax: 855-515-0804 * Email: faptcases@ezettyfs.org

Phone contact ☐ Yes ☐ No Length and frequency of phone contact:____________________

Reason for referral ***(presenting problem: requesting step down from hospitalization, step up from other community based level of care, risk of current hospitalization, parenting support, etc.)***	
Current and historical behavioral health needs/areas of concerns for child or caregiver (include *SI/HI, AVH, etc*)	
Current / historical SA diagnosis and treatment:	
MH diagnosis	
Medical diagnosis (if applicable)	
Current Medication(s) if applicable	
History of self-harm and or violence to others:	
Recent interventions attempted ***(hospitalization, Residential, Crisis stabilization, IIH, Psychiatric Medication management, MH CM, MHOP Therapy etc)?***	
Current placement	

Parent / Caregiver Identified needs

☐ Parenting skills ☐ Life Skills ☐ Co-parenting skills ☐ Effective communication skills ☐ Housing resources ☐ Substance use/abuse services ☐ Domestic Violence services ☐ TANF/Childcare/SNAP/WIC

☐ Psychiatric Services ☐ Other: ____

Trauma/Family History (check all that apply)

☐ Neglect ☐ Physical Abuse/Assault ☐ Emotional Abuse ☐ Sexual Abuse/Assault (victim)

☐ Witness of Domestic Violence ☐ Witness of Community Violence ☐ Traumatic Grief/Separation

☐ Caregiver Mental Illness ☐ Caregiver Criminal Behavior/Incarceration ☐ Caregiver Drug Use / Abuse

☐ Serious Accident/Illness/Medical Procedure

Form Completed By:

EZETT Staff only

Date received: Reviewed by: